The Culture of Medicine and Disparities in Treatment and Healthcare

Mary-Jo DelVecchio Good,Ph.D
Department of Global Health and Social Medicine,
Harvard Medical School

VA Equity Research Conference, Boston
September 13-14, 2010

Political Conversations on Culture Matters in Medicine and Healthcare

1. "Culture Counts": *Mental Health: Culture, Race and Ethnicity*, 2001; Surgeon General's Report on Mental Health (1999). Tension between universalism and particularism, between equality of care and identity politics and culturally specific services.

2. *Unequal Treatment* (2002-2003): Documenting disparities, upended emphasis primarily on patient culture, race and ethnicity to include the culture of medicine and institutions providing care, training health professionals, and conducting health research.

3. *Shattering Culture* (2010); beyond the pentad; responding to patient hyperdiversity in the context of a sea change in demographic profiles of clinicians, healthcare staff, and patient populations.

A political shift in the "meaning" and use of "culture" in studies in and of medicine…

- 1970s-1990s Era of studying patient cultures (particularistic) with scant attention to the culture of medicine (universalistic) (Ems)

- 1990s   Era of research documenting inequalities and disparities in health status and in medical treatment (NIH and Identity Politics)

- 2000s Era of examining institutions of health care, formulating public as well as professional policies and practices, designed to redress disparities (Cultural Competence; Redressing Disparities)

- 2010 – Era of "a more informed universalism" and of culturally tailored modalities of care, stressed however by financial limits, or back to inequalities as well as disparities.

The culture of medicine and disparities and inequalities in treatment

- IOM question: "How could well-meaning people (healthcare providers) provide inequitable care to minority and non-minority patients?"

- "How does the culture of medicine including the training of medical students and residents and the organization and delivery of health care affect patient treatment to produce documented disparities in therapeutic action and the quality of care?"

- Questions of inequalities in care and access or disparities and bias controlling for differences in access and coverage (Julie Richmond argued for a focus on inequalities, rather than disparities – the politics of disparities discourse)

- Initial Findings: the medical gaze, hierarchies of valued knowledge, time and efficiency, the medical machine, the hero docs and social medicine
- (see IOM chapter by Good et al, 2002; reprinted in Romero et al, 2005)

Cultural Complexities and Disparities Clinician Perspectives on IOM

- Multidimensional processes are at the root of different types of disparities and inequalities in health status and medical treatment

   1. Socialization of medical students and residents into the biologically dominant medical gaze, despite social medicine experiences

   2. Learning medicine to see, speak and create medically meaningful narratives, editing patient life narratives to include that which is immediately relevant to clinical decisions at hand

   3. Creating clinical narratives for patients, biomedical stories through which physicians explain to patients their disease diagnoses and treatment options, course and goals, fitting patients into the medical world of treatment.

Clinician Perspectives: Time and Efficiency and Socially Complex Problems

Derailing the medical machine with "socially complex problems

"Patients who don't fit into the medical machine are the ones who may not get offered the latest therapeutic interventions. We are all cogs in it, not just the docs but the patients too. And the more we fit into our role, the smoother the machine runs.

I feel bad about dosing a social problem. If chaos is in their life, patients don't get referred to high tech care, to cath, because they have difficult social situation, and black physicians do this too. "   -- Cardiology fellow

"In today's practice environment we need cooperative patients because of the tightness of time". – Senior attending

New Research: Clinician Responses to Disparities and Cultural Diversity

- Major policy and training efforts in cultural competence; successes and limits

- Major policy changes in aggressively striving to correct disparities within medical institutions and public policies (ie Menino's charge, government charges)

- Cultural ideologies of clinics and identity politics

- Check box doctoring and the current political economy of medical care → new hero docs challenging the madness of coverage and financing

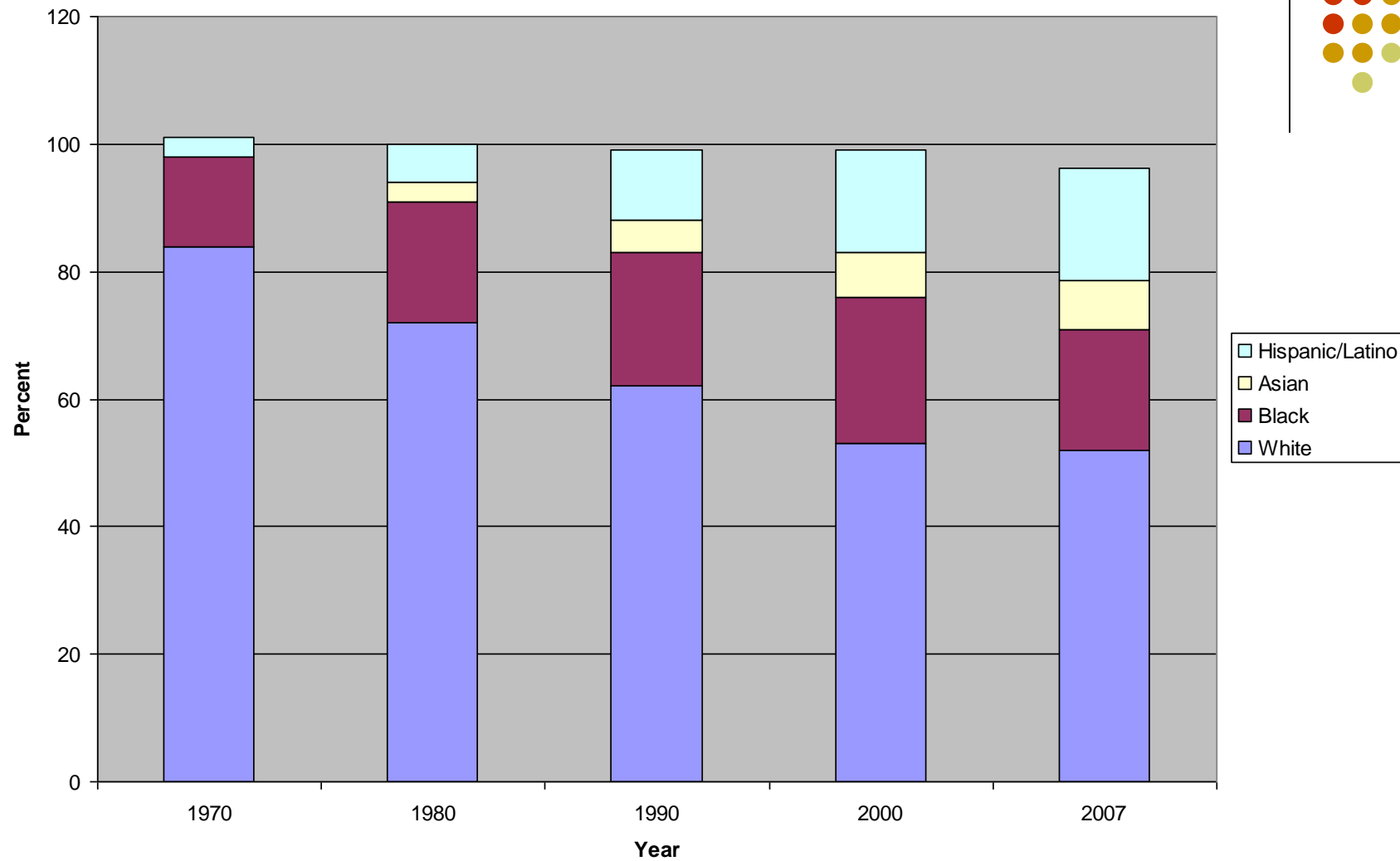# Recent Research: RSF projects on Culture and Medicine, 2006-2010

- How does culture count in American Medicine? How is the concept of culture used in American Medicine and Health Policy?

- How do our institutions of care and clinicians respond to increasing patient diversity – by ethnicity, class, race, nativity, immigration and citizenship status and insurance coverage?

- Do culturally specific services make a difference in the experience of patients and clinicians, in the quality of care, in reducing disparities and inequalities in care, in enhancing social trust? What role in times of economic crisis and limited universal coverage?

- Is there a role for medicine's and psychiatry's ideologies of universalism and altruism to reduce inequalities and disparities and increase social trust?
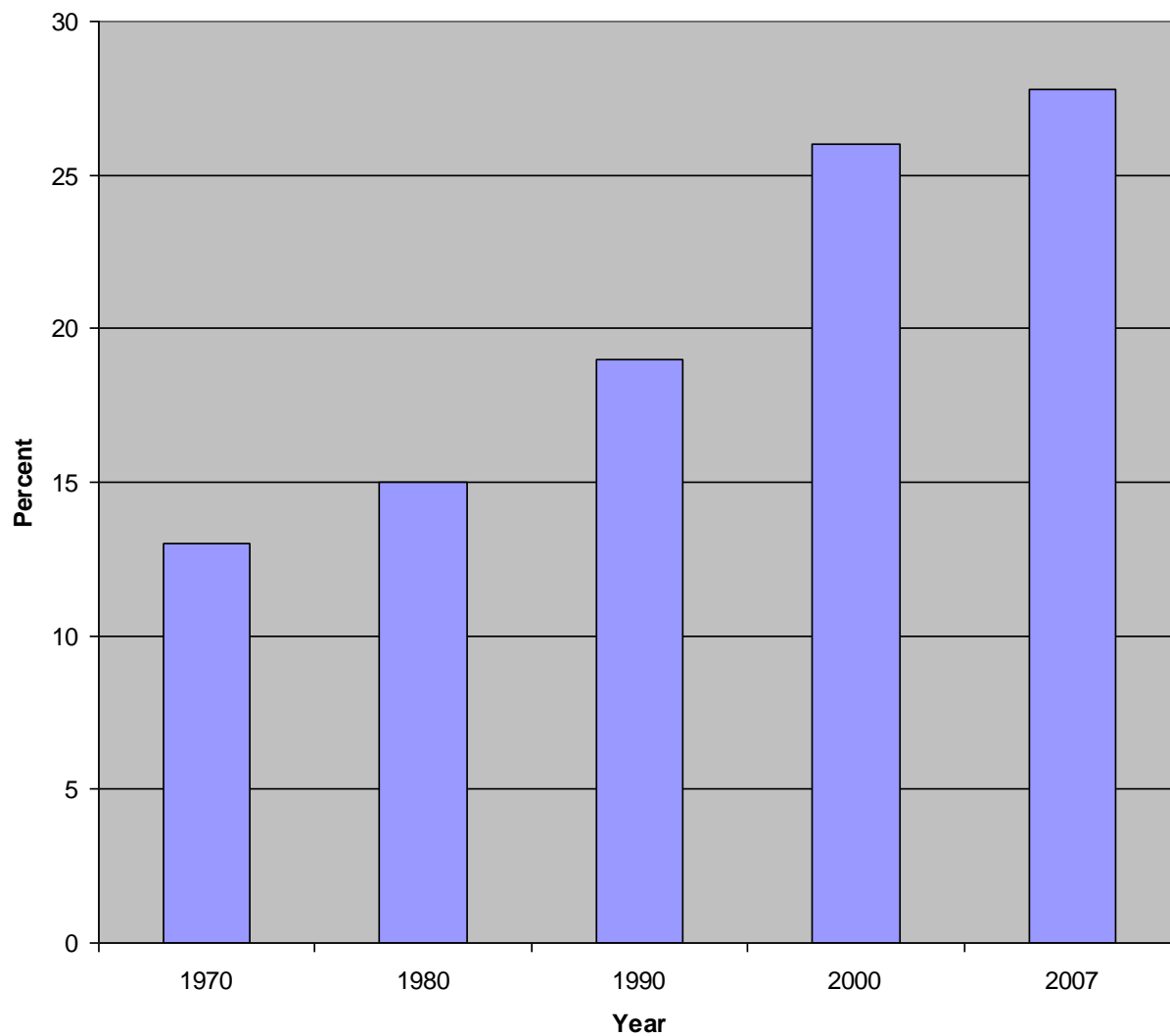
RSF : Boston and Environs

- Boston is historically interesting in the "culture counts" movement, as the first culturally tailored community clinics in the US were established in Boston to treat Italians and African Americans in the early 1960s.

- Boston's Mayor Menimo charges the city's health care institutions to redress the disparities in health status and in health care following the publication of *Unequal Treatment.*

- Psychiatry and mental health services in the greater Boston area have responded in diverse ways depending on place, communities of practice, and geographies of population change. Disparities and culturally specific services are deeply tied into the dramatic changes in Boston's demographic profile.

Suffolk County by Race/Ethnicity 1970-2007

Foreign Born in Suffolk County 1970-2007

Bar chart showing Percent (y-axis, 0 to 30) by Year (x-axis). Legend: Proportion Non-Native Foreign Born: Suffolk County 2007.

Year	Percent
1970	13
1980	15
1990	19
2000	26
2007	28

Anthropological Methods

- Sites – mental health clinics
  - The Urban Mother Ship -- Global Reach, global patients
  - The Neighborhood Community Clinic, Local Reach with "hyperdiverse" patient and clinician population
  - The Culturally Specific Outpatient Clinic at Teaching Hospital – Spanish speaking immigrant population and others
  - The Private Hospital --- open to all, takes all coverage
  - The Suburban Community Hospital – Local Reach
- Sample -- interviews
  - 192 clinicians and other healthcare staff
  - 55 patients and their clinicians

Interviews by Profession

Total Interviews   **N= 192**

Psychiatrists, Psychologists and other MD's
(M.D. Psychiatrists/PhD. Psychologists/Other MD's)   **72**

Other Mental Health Professionals
(Social Workers/Mental Health Counselors with MA Degree)   **27**

Other Health Care Staff
(Nurses/Mental Health Workers/Occupational Therapists/Dieticians)   **27**

Patient Support Staff
(Interpreters/Chaplains/Advocates/Mental Health Associates)   **47**

Administrative Support Staff
(Security/House Keeping/Dietary/Clerical)   **11**

Management Support Staff
(Non Medical Administrative and Clerical Managers)   **6**

Basic and Clinical Researchers   **2**

Identified Backgounds: (192)

- 54 Americans (51 whites, 3 blacks)
- 69 European (including 20 white Jewish)
- 8 Caribbean
- 20 Latin American, Puerto Rican, Dominican, Mexican
- 11 African
- 6 South Asian
- 7 East Asian
- 3 Middle Eastern
- 13 Mixed

What have we learned?

- Boston's clinical settings are environments of cultural "hyperdiversity" (Seth Hannah) challenging attempts at "matching" and creating oddly tailored culturally sensitive services.

- "Culture" has multiple and nuanced meanings for clinicians, staff, and patients; universalism is a dominant ideal in psychiatry yet clinicians acknowledge the importance of understanding patient cultures, as well as language, as significant for tailoring therapeutic actions. Nurses and social workers discuss cultural competence with greater frequency; psychiatry residents (very multicultural groups) revolt. Cultural competence is often a negatively loaded phrase for many physicians but not for social workers and other health care staff.

- "Culture" and the OBAMA factor give new meaning to disparities and inequalities in health care. Immigrants, legal and undocumented, fear the Massachusetts experiment. Clinicians worry about the impact on quality of care and projects to reduce disparities with the loss of "free care." The cultural ideology of clinical settings are stressed by financial short falls and limits to care. Check box psychiatry becomes a technological mode. Psychiatrists seek ways around these technical rationality instruments to provide quality care they believe their patients need. A siege mentality begins to plague mental health services. Disparities and inequalities are generated by political economy of care from the clinicians' perspective.

Culture in the Context of Highly Diverse Demographic Profiles

- Population of greater Boston in 2007 is 28% foreign born. 29% of healthcare providers in this study are foreign born as are over 30 % of patients. 32 % of the health care staff are self identified as non-white; 47% of physicians are women. The traditional image of white, male, doctors caring for immigrant or minority patients is partial and outdated.

- Interviews suggest a new era of cross race and ethnicity relationships between clinicians and their patients. Clinicians report that they work hard to gain patient trust; staff note that clinics mount many efforts to build institutional and social trust with patients from diverse backgrounds. Healthcare like the military is an industry that provides pathways to economic inclusion and citizenship.

- Providers note the challenge of caring for non-English speaking patients, the limits of translation, and the benefits language matching. Ethnic "matching" is complex for patients and clinicians. Attempts to match patients to providers are at times rather hilarious (Roman Catholic Congolese male priest for a Somali Muslim female since both are "African). Matching ignores class and status differences and raises the question of how to create "a more informed universalism" in providing patients quality care.

Clinical Environments of "Hyperdiversity" *(after Seth Hannah)*

- Hyperdiversity
  - situations in which the link between racial/ethic identity and "culture" is broken
  - meaningful differences exist along many dimensions in addition to race/ethnicity/nativity/culture

- Five Domains:
  - Multiplicity (of ethnic/cultural groups)
  - Ambiguity(racial ethnic identity not easily labeled or understood)
  - Simultaneity (individuals occupy multiple racial/ethnic categories)
  - Misidentification (patients mistakenly labeled as member of particular ethnic or racial group)
  - Misapplication (patient is correctly identified but does not share culture of group)

Clinicians on "Culture" and Therapeutic Moments

On working with Spanish speaking patients, a Spanish speaking psychiatrist:

Q: "Do you feel culturally similar to either of these patients?"

A: "Culturally similar, not really." …They are ready, interested in getting treatment so I don't have to fight them, they are motivated". "Engaged." "I have connection to both of them."

A: I address the barriers in the way, psychological, social. I will just continue meeting with patients until I find out…

:

On working with an Ethiopian woman with whom he must use an interpreter:

A: "I am at a loss. She won't look me in the eyes, she is very thin, looks sick, has severe headaches, seems not to be yearning for her country. "Some sort of victim of some sort of war?" for me it is "how do I connect? What is the area when I would say… and she would feel ok doctor, you know what I mean. For me that is the therapeutic moment!

A: The only thing I can commit myself to is to try and understand what you have but I do not know what you have – she wants to come back …..very guarded with the interpreter from her own community…

I

Patients on Culture and Relationships with their Clinicians

- African American female with anxiety disorder speaking about her Jewish male psychiatrist:

"I was worn out .. I think he is one of those people that you feel something chest-to-chest, breast-to-breast, when you talk with him and I said 'I can't move out of Boston, I'll lose Dr. *.

I feel similar. I don't feel different. I feel like he and I are both human beings. He's male, I'm female, I'm his patient and he's my doctor. I feel like we are more similar than different.

Not matching…but caring

African American female with depression and somatization, life history of domestic abuse, on her Peruvian psychiatrist…

"What is he Hispanic or something? Doesn't matter with me. He gets his point over. It not like oh boy I don't get what he is saying and need to listen 3 times over. ***It's NOT that kind of background.***

"I know one thing, he understands, although I'm from Alabama and I'm as plain as day and night or as plain as day, …he makes himself clear to the best of his knowledge and I make myself clear to the best of my knowledge. I don't see any problem there. I don't see any problem that he sees in me.

On therapy: "I have to continue to talk or I fall into a depression stage. I feel like it's my second home (being in therapy, coming monthly).

Patient Relationships: Rejection of "Matching"

Dominican professional, 40s, with depression and panic attacks (possibly attaques de nervios) from economic stress, with her Somali psychiatric social worker

Q. how do you feel about the quality of care –

P. Very good. The things we can talk about during the visit. And besides that, she can relate more that she comes from Africa, then the situation of how it is in my country, with food, or the economy…

Q. On matching:

P. "No –I am fine.

Strong rejection of matching. Discusses various clinicians of diverse backgrounds, finds most helpful.

Chinese immigrant professional

"I think its more useful to talk to someone who is not from my background. I seem to have some kind of resentment issue towards people of similar ethnicity. I don't know where that comes from. …

At one point Dr. Y asked me if I had issues with him as a male figure because I have authority issues with males..I said frankly no because you're white. Psychiatrists are mostly white, a stereotype, white male. Although Dr. J was black female, very helpful to talk to.

One big part of coming here is that my parents don't know about it. The stigma of mental illness - it's better to hide it than to seek help – quack doctors for them.

"Matching is more a personality, style sort of thing ,,,I have my own clients – language – everything else should not be relevant."

In-patient services

Black male, in US since teen years, DX: schizophrenia, 30s. on the hospital and staff.. Second hospitalization in a month. Living under a bridge.

On staff: "They're all good. They'll do anything to help you out. [Like?] Like talking, cigarettes, stuff like that."

On docs: Doctors have been here everyday with me. Dr. D. here everyday. It couldn't be better. It couldn't be better for anybody. A very good place to be. [why?] They don't judge you. It feels like home.

On "matching" Q. Are most staff people here white? (Many are African students working as psych techs)

P. "White?" Oh, that's not a problem. I don't see colors. I've never been able to see color in people. I only judge their words and actions. That's the only way I'll judge someone."

Q. Do people here understand your Haiti experience? "Yes they understand, because they've been doing this for a long time. They have the experience of healing people, talking and everything. That's how they learn. I'm not prejudiced whatsoever, of anybody.

Patients on Clinical Culture…"home language"

" My experience at X other than a couple of instances its been very positive, I refer to it as home cooking intravenous. I say I come back here to get my mail."– Male, Russian immigrant

Future Directions

- Disparities or Inequalities?

- Beyond the census and NIH pentad?

- The politics of the science of disparities – limits to identity politics, categorical thinking, hypothetical cases, non-field based or observational studies

- New field studies, ethnographies

- Historical trends, new disruptions

- Empirical Questions; are NIH style models for research limiting progress?

Future Directions cont'd

- Attend to a critical analysis of the culture of medicine in its broadest meaning and in different practice and training environments and geographical regions.
  - Time, efficiency and efficacy and the medical gaze are useful starting points
  - but projects should examine behavioral modeling and hierarchical relationships that may influence treatment choices by patients as well as patterns of care, the cultures of communities of practice.

- Examine the political economy of cultural practices in medicine, from the organization of delivery systems to the financing of biomedical innovations and practices, the justification for choice of treatment and care. What is marketed, to whom?

- Examine the practice arrangements of minority physicians by ethnicity, age, region of US (urban, rural, state); their struggles and restrictions.

- Explore how the sea change in ethnicity and race of medical students, physicians, nurses and health care staff affects the provision of care to ethnic and racial minorities, new immigrants, the poor, and other Americans (vignette from B and W).

Future Directions…

- Identify interventions and programs that have been successful in medical and nursing education and have influenced the way care is provided to ethnic and racial minority patients.

- Assess the success of programs directed to redress imbalances in care such as minority outreach programs and clinics; what are the positive lessons, negative if unintended consequences and avoidable difficulties.

- Examine the use of culture in American medicine and health policy (a project that has evolved for me over the past decade with a focus on mental health care and psychiatry.)

- The overarching investigation seeks to document how ideas about culture, diversity, and inequality have been shaped in and by American medicine, its institutions of research and training, patient care and health policy, and how these ideas have changed in response to a rapid increase over the past decade in the cultural and ethnic diversity of patient and provider populations, in tandem with vast changes in the political economy of health care.

Larger questions about American society

How tensions between two competing impulses in American democracy --- the particular and the universal--

- the view that culture matters and institutions should respond explicitly to cultural diversity, linguistic communities, and ethnic or national heritage

- technologized into the "cultural competence" industry (still thriving; is it useful?)

- and a commitment to universality and intentional blindness to issues of race, religion and ethnicity

- – play out within American health care institutions in an era of increasing financial restrictions on healthcare spending especially in the area of mental health care?

DSM 5.0 and The New Cultural Psychiatry

" *I am all for universalism, but for a more informed universalism*"

. . . Roberto Lewis-Fernandez, DSM 5.0 cultural psychiatrist leader.

Shattering Culture Research Team

- NIMH Predoctoral Fellow: Seth Hannah

- Psychiatrists: Larry Park, Antonio Bullon, Marina Yaroshenko, Alastair Donald, Margaret Lyons

- NIMH Anthropology Fellows: Elizabeth Carpenter-Song, Lisa Stevenson, Ken Vickery, Sarah Willen, Joe Calabrese, Sadeq Rahimi

- RA Staff – Matt Lakoma, Elissa Poorman, and many Harvard College student assistants